Patient Information Form

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Patient Name: _____ Date of Birth: _____

Street Address: _____ Gender: ☐ Male ☐ Female

City / State / Zip: _____ Primary Care Physician: _____

How did you hear about our office? ☐ Established Patient / Friend / Neighbor ☐ Internet ☐ Insurance Co. ☐ Walk-in

Name of Mother: _____ Date of Birth: _____

Street Address: _____ Home Phone: _____

City / State / Zip: _____ Cell Phone: _____

Drivers License No: _____ SSN: _____

Name of Father: _____ Date of Birth: _____

Street Address: _____ Home Phone: _____

City / State / Zip: _____ Cell Phone: _____

Drivers License No: _____ SSN: _____

Primary Insurance Information

Insured Name: _____ Date of Birth: _____

Name of Employer: _____ Copay: _____ Preventive Coverage? ☐ Y ☐ N

Policy ID: _____ Group Number: _____

Secondary Insurance Information

Insured Name: _____ Date of Birth: _____

Name of Employer: _____ Copay: _____ Preventive Coverage? ☐ Y ☐ N

Policy ID: _____ Group Number: _____

Emergency Contact Person: _____ Daytime Phone: _____

List name, sex and birth date of all siblings: _____ _____

_____ _____ _____

Please bring patient's insurance card to every visit. Parents/Guardians are responsible for notifying our office of changes of address and/or insurance coverage. Please note that whomever brings the patient(s) to their appointment is responsible for paying the Insurance Co-pay if applicable. When writing a personal check, please have Drivers License or State ID available.

Authorization To Release Medical Information: I hereby authorize St. Clair Pediatrics to release any information acquired in the course of my examination or treatment to any insurance company against which claims are filed on my behalf. I hereby authorize payments directly to St. Clair Pediatrics of the medical benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for payment of all charges for services rendered and that if my insurer fails to pay any portion of these charges for any reason, I will be responsible for all sums due St. Clair Pediatrics. If my account is sent to an attorney or collection agency, I will be responsible for any collection fees and/or court costs. A copy of this signature is as valid as the original.

_____ _____

Signature of Patient or Legal Guardian Date